



**IN THE APPEAL BEFORE THE APPEALS COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES
HELD VIA THE MICROSOFT TEAMS VIDEO AND AUDIO CONFERENCING TECHNOLOGY
(Instituted in terms of the Medical Schemes Act No.131 of 1998)**

Case number: **CMS/86647**

In the matter between:

B

APPELLANT

AND

KEYHEALTH MEDICAL SCHEME

RESPONDENT

ORDER WITH REASONS

THE PARTIES

1. The Appellant is B (“the member or the Appellant) a member of the scheme in terms of the definition accorded to a “*member*” under the Medical Scheme’s Act 131 of 1998.
2. The Appellant represented himself at the hearing.
3. The Respondent is Key Health Medical Scheme (“Keyhealth, the Scheme or the Respondent”) a Medical Scheme duly registered and regulated under the Medical Schemes Act 131 of 1998 (the “MSA.”)
4. The Respondent was represented by Ms X, the Clinical Specialist of the Respondent.

INTRODUCTION

5. This is an appeal in terms of section 48(1) of the Council for Medical Schemes Act 31 of 1998 (“the Act”) pertaining to a decision of the Registrar dated 27 February 2025.¹
6. This section provides that:
“(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council.”
7. The Appeals Committee heard the Appeal on 3 December 2025 via an audio and video conferencing link.

BACKGROUND

8. On or about 5 May 2024, the Appellant was involved in an accident wherein he dislocated his ankle.
9. Post surgery on his ankle, he underwent physiotherapy treatment.

¹ Page 137 to 145 of the Bundle.

10. It is alleged by the Appellant that the Respondent used the Appellant's day-to-day benefits instead of his Prescribed Minimum Benefits ("PMB") to fund the physiotherapy treatment resulting in the depletion of the Appellant's day-to day-benefits.
11. The Appellant filed a complaint with the Registrar in terms of section 47 of the Act against the funding decision of the Respondent.
12. The Registrar issued a ruling in favour of the Respondent directing that the rules of the scheme have application and that the funding decision of the scheme was in accordance with the scheme's registered rules.
13. The Appellant then filed a section 48 appeal to the Registrar's decision, the subject matter of this Ruling.
14. This Ruling follows the hearing of the Appeal on 3 December 2025.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

15. The relationship between the member and the scheme is governed by the terms of the contract ("the schemes rules") that the member concluded with the scheme. The contract in turn is governed by the Act and the regulations (as amended) made in terms of the Act.
16. Section 32 of the Act stipulates as follows: "*Binding force of rules —The rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.*"
17. Regulation 8 stipulates as follows -
"*8. Prescribed Minimum Benefits.—(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.*"

WIDE APPEAL

18. This is a wide appeal. The Appeals Committee may therefore consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.
19. The burden of proof rests on the Appellant who must prove on a balance of probabilities that the appeal should succeed.

THE ISSUE IN DISPUTE

20. The issue to be determined is whether the scheme acted in accordance with the registered scheme rules and the Act read with the regulations.

THE APPELLANT

21. The Appellant placed on record that he was involved in an accident that resulted in the dislocation of his ankle. He had surgery on his ankle followed by post-surgery physiotherapy.
22. The complaint of the Appellant is that the Respondent used his day to day benefits instead of his PMB benefits which resulted in his day to day benefits being depleted and him being threatened with legal action by the physiotherapist.
23. The Appellant submitted that it was his understanding that payment for physiotherapy was a PMB and should not have been funded out of his day-to-day benefits.
24. The Appellant submitted that he consulted with the physiotherapist monthly, except in the month of June 2024, for a total of five sessions. This number of sessions he submits is a reasonable number of sessions for rehabilitation following an open reduction to his ankle.
25. According to the statement of account presented to the Respondent, the physiotherapist claimed under the following codes:
 - 25.1 Code 405 – Manipulation/Mobilisation of Joints;
 - 25.2 Code 203 – High-Frequency Currents (Ultrasound);
 - 25.3 Code 107 – Low-Frequency Currents (Interferential Therapy);

- 25.4 Code 501 – Rehabilitation requiring the undivided attention of the physiotherapist (30 min); and
- 25.5 Code 303 – Myofascial release/soft tissue mobilization.
26. According to the Appellant these codes indicate that active therapy was provided to him during the sessions, ensuring that his recovery was properly managed and monitored. The physiotherapy sessions took place on the following dates -
- 26.1 27 May 2024;
- 26.2 24 June 2024;
- 26.3 28 June 2024;
- 26.4 19 July 2024; and
- 26.5 15 August 2024.
27. The Appellant submitted that on 27 May 2024, two weeks post-surgery to his ankle, his range of motion (“ROM”) was significantly reduced, with a Lunge Test of -15cm. By 19 July 2024, at 11 weeks post-surgery, whilst he had regained a normal walking pattern, his ROM was still decreased with a Lunge Test of 4.5cm (Lt = 12cm). This does not, per the Appellant, fall within the normal range of motion, contrary to the Respondent’s conclusion.
28. The Appellant submitted that physiotherapy for rehabilitation after treatment until a plateau is reached is included in the PMB level of care for his condition. It is unreasonable for the Respondent to expect him to perform exercises designed for later stages of his recovery at the beginning of the process. A structured rehabilitation plan with professional supervision was necessary to ensure proper healing, prevent complications, and restore full function. A home exercise program alone would not have been sufficient to achieve these outcomes.
29. The Appellant submitted that his condition is a PMB condition requiring a PMB level of care and should be funded as a PMB.
30. As a result, the Ruling of the Registrar is not correct, and the appeal should be upheld.
31. The relief sought by the Appellant is that the account of the physiotherapist is settled by the Respondent in full; and the reinstatement of his day-to-day savings account.

THE RESPONDENT

32. The Respondent submitted that indeed the Appellant was admitted to hospital from 5 May 2024 to 8 May 2024, under ICD 10 code: S93.3 - dislocation of other and unspecified parts of the foot, with the primary procedure code of 28585 - Open treatment of talotarsal joint dislocation, includes internal fixation, when performed.
33. On 6 May 2024, the Appellant consulted with GJ Keet Inc, a physiotherapist. Based on the tariff codes claimed, the Appellant was provided with a post operative exercise plan for home use which was paid for by the Respondent. The PMB entitlement codes are 902H and S93.3.
34. The Respondent referred the Appeals Committee to CMS Script 5 of 2015 in support of the Respondent's submission wherein it states that –
“It is understandable, that depending on the condition a member suffers from there will be deterioration that requires intensive treatment for a period (e.g. muscle spasm etc.). The provider must submit a report and motivate for funding as PMB. Unfortunately, weekly visits to all the therapists may not be affordable to medical schemes and as such the scheme may discontinue funding once a patient reached the plateau. Periodic follow up to assess functionality and support the family to continue therapy may be necessary at periods agreed by the medical scheme and provider. Please note that the need is always based on the patient's clinical circumstances and progress.”
35. The Respondent submitted that the Appellant was given a post-operative exercise plan by a physiotherapist after his discharge from hospital. However, the Appellant continued to consult with the physiotherapist instead of doing the home exercises as prescribed. Thus both the Appellant and the physiotherapist deviated from the treatment plan.
36. Furthermore, in accordance with the CMS Script, a report from the physiotherapist would be required to determine if there is any functional benefit from the continued physiotherapy sessions or not; and the Scheme will review the matter as PMB, subject to the receipt of the following clinical information/documentation:
- 36.1 specialist letter of motivation and referral letter;
36.2 FIMTM score functionality report; and

36.3 initial and progress report from the Physiotherapist.

37. The Respondent is further, allowed to have protocols in place to fund PMBs and to request the above-mentioned information to review the matter as PMB. The Respondent submitted that the accounts received were processed in accordance with the benefits available and paid from the Appellant's available day-to-day benefits. Further that, it's incorrect that the claims were funded from the Appellant's medical savings account.
38. The Respondent submitted further that the physiotherapist, saw the Appellant during his admission to hospital on 6 May 2024, where he fully evaluated him and provided him with a home program. It should be noted per the Respondent, that in the later report of the physiotherapist he failed to mention this in the report.
39. According to the Respondent, a person's range of motion will be affected soon after an operation to correct a dislocation, as mobilization of the joint area will not be possible whilst in a cast. There will still be swelling of the area around the joint, and strength and stability will be affected. This is why non-weight bearing mobilization is prescribed to the Appellant with passive exercises post-surgery to his ankle. Thus, the Appellant could have continued/started the home exercise program that was supplied to him in hospital on 6 May 2024.
40. The Respondent submitted that based on the claim's history, the physiotherapist claimed for outpatient treatment on 27 May 2024, 10 June 2024, 21 June 2024, 28 June 2024, 19 July 2024; and 15 August 2024.
41. According to the physiotherapist's report the Appellant had normal range of motion on 19 July 2024, however, the practice still submitted a claim for rehabilitation on 15 August 2024. The report further indicates that the Appellant's, cast was removed on 27 May 2024, but the follow-up visit with the Orthopaedic surgeon was only on 27 June 2024. The referral letter from the Orthopaedic surgeon Dr XXXX, was only dated 27 January 2025, and has no clinical information to justify extensive physiotherapy.
42. The Respondent submitted that the physiotherapist did not provide specific clinical details other than normal post-operative state/symptoms expected, as to why the Appellant required continued outpatient physiotherapy. The report does not provide sufficient clinical information to justify why a 25- year-old male patient would require extensive outpatient visits.

43. It is further the contention of the Respondent that post operative pain, joint stiffness and initial decreased range of motion is expected after surgery for weeks/months and an outpatient home program will be as effective to follow to improve range of motion and decrease stiffness.
44. The Respondent confirmed that it approved a follow-up consultation for 10 June 2024, to evaluate the Appellant's progress with the home exercise program (5 weeks post operative), for payment in full as PMB.
45. The Respondent concluded that it stands by its decision to reject the claims for services rendered on 21 June 2024, 28 June 2024, 19 July 2024 and 15 August 2024 as the Appellant's day-to-day benefits for 2024 were depleted; and because the physiotherapist did not provide the Respondent with the necessary clinical information to assess the Appellant's condition.
46. The Respondent asks that the Appeals Committee confirms the Registrar's decision that the Respondent in its funding decision has not contravened the rules of the scheme, the Act read with the Regulations.

CONSIDERATION OF THE MERITS

47. In this matter, upon receipt of the member's complaint, and after investigating the matter, the Registrar ruled as follows *"the Registrar finds that in this case the Respondent acted in compliance with the Act and its registered rules. Therefore, the Respondent cannot be compelled to fund physiotherapy account, for the reasons stated above."*
48. The Registrar further arrived at a decision after referring the case to the CMS Clinical Review Committee the ("CRC") for a clinical opinion on whether the procedure is a PMB requiring a PMB level of care for the member's condition.
49. Having reviewed the submitted clinical reports, the CRC advised as follows: *"ICD10 code S93.3 – "Dislocation of other and unspecified parts of foot" is a Prescribed Minimum Benefit (PMB) condition under Diagnosis and Treatment Pair (DTP) code 902H. This DTP code refers to "Closed fractures/ dislocations of limb bones / epiphyses – excluding fingers and toes. Treatment component specified for DTP code 902H is "Reduction / relocation."*

50. In this matter, procedure code 28585 – Open treatment of talotarsal joint dislocation, includes internal fixation of the Appellant’s ankle. It is common cause that the Appellant’s condition is a Prescribed Minimum Benefit condition, as listed in the PMB Regulations under the Diagnosis and Treatment Pairs (the “DTP’s”). The Appeals Committee is satisfied that the surgery performed is a PMB level of care for the member’s condition.
51. Turning to Regulation 8, it is specified that the diagnosis, treatment and care costs of PMBs must be paid in full. As physiotherapy is part of treatment for the Appellant’s PMB condition after surgery, this treatment must be paid in full if the services were obtained from a Designated Service Provider (“DSP.”)
52. However, the Scheme is permitted to have protocols in place to fund PMB’s and are not in contravention of the Act or the rules to request the following information, as it did, to review the matter as a PMB i.e.-
- 52.1 the Specialist letter of motivation and referral letter;
 - 52.2 a Functional Independence Measure (FIMTM) score functionality report;
 - 52.3 an initial and progress report from the Physiotherapist; and
 - 52.4 that the Physiotherapist must submit the requested information to the Scheme to allow them to make an informed PMB funding decision.
53. The dispute of the Respondent is that the treatment prescribed for the Appellant’s PMB condition is not PMB level care, hence it is within the Respondent’s purview and the rules of the scheme / scheme protocols not to fund it in full. On the other hand, the Appellant asserts that the physiotherapy treatment of his condition ought to be funded in full by the Respondent, since it is a PMB level of care.
54. In terms of the provisions of Regulation 8(1), the Respondent is enjoined to fund in full, and without co payment or the use of deductibles, the diagnosis, treatment, and care costs of prescribed minimum benefit conditions. Further to that, Regulation 8(4) empowers the Respondent to deploy appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorization, the application of treatment protocols, and the use of formularies.

55. The Appeals Committee is satisfied and supports the view of the CRC, that the surgery performed on the Appellant constituted a PMB level of care for the Appellant's condition. In this matter, physiotherapy does form part of treatment for the Appellant's PMB condition after surgery. This being the legal position, the treatment ought to be funded in full as envisaged in Regulation 8(1) of the Act.
56. The submissions of the Respondent indicate that in consideration of its funding decision the Respondent has a right to request additional information from the physiotherapist to enable it to make an informed funding decision.
57. It is on record that the Respondent requested such clinical information from the physiotherapist and based on this information the Respondent found that there was no clinical information to justify extensive physiotherapy. Furthermore, the physiotherapist did not provide specific clinical details other than normal post-operative state/symptoms expected, as to why the Appellant required continued outpatient physiotherapy. In turn, the Appellant argued that physiotherapy for rehabilitation after treatment until a plateau is reached is included in the PMB level of care for his condition. Further that, a structured rehabilitation plan with professional supervision was necessary to ensure proper healing, prevent complications, and restore full function.
58. Based on the submissions before the Appeals Committee, the Respondent provided funding for the physiotherapy for the Appellant post-surgery to his ankle. The parties are apart on the Respondent's contention that the physiotherapist did not provide sufficient clinical information to corroborate why the Appellant required extensive outpatient physiotherapy.
59. It is important to note that each matter must be considered on its own merits.
60. In considering the Respondent's funding decision it is not contrary to the Act, read with the rules and the rules of the scheme for the Respondent to request and to rely on amongst others the clinical motivation from the treating provider, in this case the clinical motivation of the physiotherapist and other supporting documents to arrive at a funding decision even in the case of a PMB condition requiring a PMB level of care.

FINDING

61. In this matter before the Appeals Committee, we are satisfied and find that the Respondent is entitled to have protocols in place in terms of its rules to request additional information from the physiotherapist; and in this instance, a detailed clinical motivation was not provided by the physiotherapist to justify the continued PMB level of care for treatment for the Appellant's PMB condition.
62. Therefore, funding will be to the extent as provided in the registered scheme rules.
63. The scheme rules, together with the Act, regulate the relationship between the scheme and its members. In this regard in terms of section 32 of the Act it is important to note that the registered rules of a medical scheme constitute a binding contract between the scheme and each individual member and are enforceable at law.
64. Having considered the merits of this appeal, the Appeals Committee is satisfied and finds that the Respondent acted in compliance with the Act and its registered rules. Therefore, the Respondent cannot be compelled to fund out-patient physiotherapy for the reasons stated above.

ORDER

65. The Appeals Committee makes the following order:

- 65.1 The Appeal is dismissed.
- 65.2 The Registrar's Ruling is confirmed.
- 65.3 There is no order as to costs.

THUS DONE AND SIGNED AT JOHANNESBURG ON THIS THE 20th DAY OF DECEMBER 2025

SIGNED
PA BECK
PRESIDING MEMBER

Dr. K. Chetty; and Dr. S. Naidoo concur